



September 14, 2021

Senator Shirkey & Members of the Senate Government Operations Committee,

My name is Alan Bolter. I am the Associate Director of the CMH Association of Michigan. CMHAM is a trade association, representing the 46 CMH boards, 10 Prepaid Inpatient Health Plans (PIHP) and over 100 provider organizations. Our members provide mental health, developmental/intellectual disability and substance use disorder services for Michigan residents in all 83 counties in Michigan.

As you are aware CMHA does NOT support SBs 597 & 598, below are some of our many concerns:

1. **COST** – Recent national study by Milliman, Michigan Medicaid Health Plans have the 2nd WORST Medical Loss Ratio (MLR) in the country: how much money they spend on actual care is 79%, which means they have an overhead or administrative rate of 21%, which includes a 3% profit margin. Page 26:

https://www.milliman.com/-/media/milliman/pdfs/2021-articles/7-7-21-medicare_managed_care_financial_results.ashx

- MI PIHP system has an average of 6% overhead / admin rate.
- $21\% - 6\% = 15\%$ difference, doing simple math on \$3 billion = **\$450 million COST difference**
- Costs have gone up in other states that have done this – IOWA: Iowa Medicaid cost increases nearly triple under managed care (desmoinesregister.com)
 - The average cost of insuring an Iowan on Medicaid has climbed nearly three times as fast since the state hired private companies to manage the program, when compared to the previous six years, new state figures show.
 - Since fiscal 2017, the first full year of privatization, the per-member cost of Iowa's Medicaid program has risen an average of 4.4 percent per year, according to the non-partisan Legislative Services Agency. In the previous six years, the per-member cost rose an average of 1.5 percent per year, the agency said.

2. Bills **do nothing to ACTUALLY integrate care**. Real health care integration occurs on the ground at the point of service delivery. SBs 597 & 598 only integrates the funding.

- Financial integration – this proposal does nothing to actually integrate care other than giving the managed care functions and funding to health insurance companies. (New Dartmouth Study Shows That Greater Financial Integration Generally not Associated with Better Healthcare Quality) <https://geiselmed.dartmouth.edu/news/2020/new-dartmouth-study-shows-that-greater-financial-integration-generally-not-association-with-better-healthcare-quality/>
 - This is not a 1 door solution – physical and behavioral health will still be siloed.
 - Health Plans do NOT provide services – they simply authorize care and pay the bills.
 - CCBHC & Health Homes are patient-centered on the ground integration efforts.

3. **Eliminates ALL public governance, oversight and accountability.** Bills wipe out the public accountability of the dollars, health plans are not accountable to boards of county commissioners, do not hold open board meetings or subject to FOIA. The bills would also destroy local community partnerships / collaborations (law enforcement, schools, courts, housing, homeless, hospitals etc) while making CMHs just another provider (eliminating their unique safety net role).

- Public oversight and accountability is needed
- Michigan Medicaid Health Plans show record profits in 2020; <https://www.craigslist.com/health-care/michigan-health-plans-post-rosy-profits-first-half-2020-blues-cross-income-lower-2019>
 - For the Michigan health plans, net income increased 54 percent to \$551.3 million from \$353.8 million, said Baumgarten, who used data from the state Department of Insurance and Financial Services. Average profit margins increased to 6.2 percent from 4.2 percent.

4. **Poor Track record on behavioral health** – Medicaid health plans have a poor track record of managing mental health benefits. Currently they are responsible for the Medicaid mild/moderate benefit for mental health services – before this change is made there MUST be more data and proof they can do the job.

- Health plans are funded to provide Medicaid beneficiaries with mild/moderate behavioral health conditions. According to MDHHS, the average number of mental health visits authorized for qualifying MHP enrollees in 2014 was 4. In 2015, only 10% of all contacts for Medicaid recipients seeking behavioral health services were with a behavioral health professional.
- [Altarum Behavioral-Health-Access Final-Report.pdf](#) – July 2019, Health Endowment Fund Commissioned a report – Access to Mental Health Care in MI, below is from page 8:
 - **Unmet need for AMI (Adults with mental illness) in Michigan is greatest for the more prevalent, mild-to-moderate conditions.** Figure 11 shows the variation in estimated prevalence and unmet need for some of the most common mental health condition diagnostic categories. The conditions with the largest shares going untreated are anxiety disorders and depressive episode. More serious conditions such as bipolar disorder, recurrent depression, and post-traumatic stress disorder (PTSD) and other stress disorders are less prevalent among Michiganders and show lower shares going untreated

Michigan's public mental health system is nationally recognized as one of the most comprehensive, innovative, person-centered and community-driven systems in the country. With that said, we believe that focusing time and attention to the items below would go much further in improving the lives of people and families served across our state:

-
- Address & expand access to mental health and addiction services
 - Access to services is a HUGE problem for those individuals who are not in the current Medicaid CMH system, they are on the outside looking in – Medicaid health plan mild/moderate benefit and those with commercial insurance services are very limited.
 - Let's not try to make Medicaid behavioral services look like commercial insurance, we should try to figure out how to expand commercial insurance for behavioral health so it looks more like the current Medicaid coverage.
 - Address the desperate need for more inpatient care settings for those most in need
 - We need more crisis and residential services.
 - Find ways to dramatically expand and increase the mental health and addiction workforce shortage
 - From front line DCWs to psychiatrists

Improving these areas would have an immediate impact on people's lives across the state.

- CCBHC & BHH/OHH must be part of the solution – patient-centered initiatives (true models of integration)

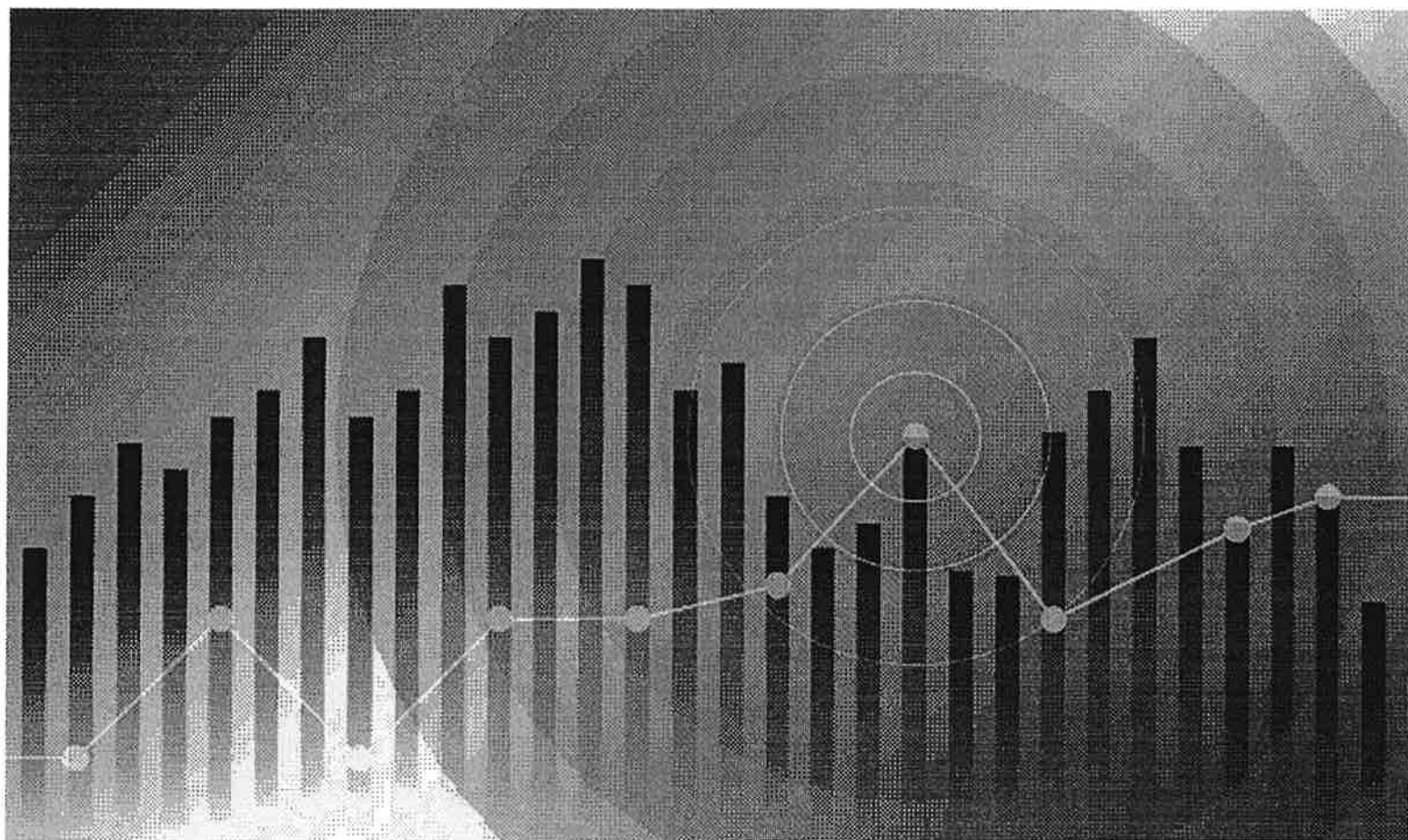
Thank you for your time and attention to these concerns.

MILLIMAN RESEARCH REPORT

Medicaid managed care financial results for 2020

July 2021

Jeremy D. Palmer, FSA, MAAA
Christopher T. Pettit, FSA, MAAA
Ian M. McCulla, FSA, MAAA
Cameron R. Kinnick, ASA, MAAA



Appendix 4: Financial results by state

While the Medicaid managed care financial results are more stable at a nationwide level, the financial results may vary significantly from state to state. Figure 18 provides the average MLR, ALR, UW ratio, and RBC ratio for each state or territory with at least one MCO included in this analysis. Please note that for this appendix an estimate for MCOs operating in multiple states was made to allocate enrollment, premiums, and expenditures to each state the MCO operates in. As a result, the total number of plans illustrated below is not equal to the total illustrated in other sections of this report. Additionally, the states may contain a limited number of MCOs in the event that certain MCOs operating in the state were not included in this report for reasons cited earlier.

FIGURE 18: STATE OF DOMICILE

STATE	N	MLR	ALR	UW RATIO	RBC RATIO
ARIZONA	7	84.2%	11.5%	4.3%	N/A
COLORADO	2	89.6%	9.5%	0.9%	504.1%
DISTRICT OF COLUMBIA	4	79.7%	17.0%	3.4%	764.8%
FLORIDA	7	84.0%	12.4%	3.6%	358.3%
GEORGIA	4	80.8%	15.6%	3.6%	486.3%
HAWAII	4	85.1%	16.1%	(1.2%)	610.4%
IDAHO	1	86.6%	11.0%	2.4%	440.4%
IOWA	2	88.5%	6.4%	5.1%	351.6%
ILLINOIS	5	87.2%	12.6%	0.2%	396.5%
INDIANA	3	87.9%	10.3%	1.8%	431.8%
KANSAS	2	83.6%	15.2%	1.2%	395.8%
KENTUCKY	6	82.4%	14.6%	3.0%	433.8%
LOUISIANA	5	84.6%	14.1%	1.3%	358.7%
MARYLAND	5	94.5%	7.4%	(1.8%)	415.8%
MASSACHUSETTS	5	83.9%	10.7%	5.4%	515.8%
MICHIGAN	9	79.0%	18.0%	3.0%	481.0%
MINNESOTA	4	89.0%	9.1%	1.8%	590.2%
MISSISSIPPI	3	79.5%	14.6%	6.0%	661.1%
MISSOURI	2	82.5%	11.5%	5.9%	535.5%
NEBRASKA	3	85.3%	12.2%	2.6%	394.5%
NEVADA	3	85.0%	13.2%	1.8%	523.6%
NEW HAMPSHIRE	3	85.7%	11.3%	3.0%	498.0%
NEW JERSEY	4	82.5%	14.5%	3.1%	501.0%
NEW MEXICO	2	81.6%	14.1%	4.4%	384.3%
NEW YORK	7	92.1%	12.2%	(4.3%)	455.3%
OHIO	5	83.3%	13.9%	2.8%	367.6%
OREGON	11	90.8%	8.4%	0.8%	378.2%
PENNSYLVANIA	6	84.1%	13.2%	2.7%	455.9%
PUERTO RICO	4	92.1%	10.3%	(2.5%)	352.0%
RHODE ISLAND	3	88.7%	10.5%	0.8%	372.1%
SOUTH CAROLINA	5	84.3%	12.9%	2.8%	687.9%
TENNESSEE	3	81.2%	16.8%	2.0%	631.8%
TEXAS	17	82.5%	11.0%	6.5%	465.6%
UTAH	3	86.0%	8.6%	5.4%	705.6%
VIRGINIA	6	85.7%	9.2%	5.1%	435.1%
WASHINGTON	5	82.9%	13.4%	3.8%	485.1%
WEST VIRGINIA	3	83.7%	10.7%	5.6%	560.1%
WISCONSIN	14	75.9%	14.2%	9.9%	581.8%

Des Moines Register

HEALTH

Iowa Medicaid's per-member cost increases nearly triple since privatization

Tony Leys The Des Moines Register

Published 3:47 p.m. CT Sep. 19, 2018

The average cost of insuring an Iowan on Medicaid has climbed nearly three times as fast since the state hired private companies to manage the program, when compared to the previous six years, new state figures show.

Since fiscal 2017, the first full year of privatization, the per-member cost of Iowa's Medicaid program has risen an average of 4.4 percent per year, according to the non-partisan Legislative Services Agency. In the previous six years, the per-member cost rose an average of 1.5 percent per year, the agency said.

The new cost figures come amid continuing controversy over whether Iowa should have hired private companies to run the \$5 billion program. The shift's supporters said it would slow growth in health care spending on the more than 600,000 poor or disabled Iowans covered by Medicaid.

The Legislative Services Agency compiled the new cost increase figures from past budget reports published by the Department of Human Services, which oversees Medicaid.

The human service department's leaders defend Iowa's transition to privately managed Medicaid and contend the per-member cost figures can be misleading. They said some years' cost totals could be inflated because they include bills paid for services that were provided to Medicaid members in previous years.

But a leading critic of privatized Medicaid said the new numbers are clear evidence the transition is not fulfilling its promises.

"From Day One, we've doubted privatization of Medicaid would save money," said state Sen. Liz Mathis, a Hiawatha Democrat. She said the numbers should be hard to dispute, since they come from the department's own reports.

Mathis said the department has yet to offer solid data backing claims that private Medicaid managers have prevented costly health problems. "They've been unable to show any data that Iowans are better off," the senator said.

Republican Gov. Kim Reynolds said in an interview Wednesday she remains confident in the promise of private Medicaid management, despite the new cost numbers.

Reynolds said Department of Human Services administrators have assured her part of the explanation for the recent spike in per-member Medicaid costs was bills incurred in past years were being paid in the current budget year.

Reynolds' Republican predecessor, Gov. Terry Branstad, ordered the shift to private Medicaid management in 2015.

The change has become a major issue in this fall's elections for governor and Legislature. Reynolds said she remains open to making changes to the program, but she continues to believe it is on firmer footing than Iowa's previous Medicaid system, which was directly run by state administrators.

"Iowans need to be confident that I, as the governor, am going to make sure we have a sustainable program in place that can take care of their loved ones," Reynolds said. She added that many Iowans are pleased with the services they are receiving under the current Medicaid system.

Reynolds said that doesn't mean she's satisfied with the way everything in Medicaid is going. She vowed to continue talking to Medicaid members, families, service providers the managed-care companies and outside experts.

"We'll find out where the pain points are and what we need to do differently," she said. "That's what I'm focused on."

Some of the per-member cost numbers were in a budget report Medicaid Director Mike Randol presented last week to an advisory committee for the Department of Human Services. Randol, who works for the department, told the committee he didn't know what was behind the numbers, which were included in a chart going back to fiscal year 2015.

After the meeting, Randol told reporters he was unsure of the meaning behind the chart included in his report.

"I didn't create that chart, so I need to go back and understand the background," he said. "I

potentially be driving the increase.”

The Des Moines Register obtained more extensive per-member Medicaid cost figures from the Legislative Services Agency. The agency prepares detailed reports for legislators on an array of issues. Jess Benson, an analyst for the agency, said he found comparable budget figures going back to fiscal year 2011.

The Medicaid cost increases for this fiscal year are partly driven by an 8.4 percent raise the Iowa Department of Human Services agreed last month to give the two managed-care companies running the program. That raise, which includes state and federal tax dollars, will send \$344 million more to Amerigroup and United Healthcare this fiscal year, which runs through June 2019.

Department of Human Services spokesman Matt Highland said this week that if per-member Medicaid costs were re-figured to reflect only the cost of services provided to members in each fiscal year, the increases would be less steep.

The cost increase for fiscal year 2018 would be just 1.4 percent instead of 6.6 percent, he said, and the increase for fiscal year 2019 would be 5.6 percent instead of 11 percent. However, his new figures did not show corresponding increases in per-member costs for the previous two years.

The chart Randol offered last week included projected per-member spending on Medicaid for the next two budget years.

It showed state administrators expect those costs to drop 4.7 percent next fiscal year, then climb 1.8 percent the following year. Those projections, however, did not include any raises the state might negotiate with the managed-care companies for those years, which could significantly push up taxpayer spending.

Des Moines Register

EDITORIALS | Opinion *This piece expresses the views of its author(s), separate from those of this publication.*

Editorial: Iowa Medicaid director again dodges questions about his \$5 billion program

Reynolds' Medicaid director again cannot answer questions about the \$5 billion health insurance program he oversees

The Register's editorial

Published 6:49 a.m. CT Sep. 20, 2018

There is something seriously wrong when Iowa Medicaid Director Mike Randol cannot answer basic questions about his program.

The man in charge of overseeing \$5 billion in taxpayer funds to provide health care to one-fourth of Iowans is again unable to explain the methodology behind information coming from his office.

The latest is a chart included in a report Randol himself presented this month to a council that oversees the Iowa Department of Human Services. It shows Medicaid costs per patient rising 11 percent this fiscal year to more than \$10,000.

That is about \$1,000 more per patient than before former Gov. Terry Branstad privatized Medicaid without legislative approval. A recent analysis from the Legislative Services Agency found per-member costs have risen an average of 4.4 percent since privatization, compared to 1.5 percent when Medicaid was managed by the state.

How could Medicaid costs be increasing? Branstad and his successor, Kim Reynolds, insisted privatization would save taxpayers a bundle. And how can spending increase when there are so many complaints about care being denied and providers not being paid?

It simply doesn't make sense, particularly when insurers have a lot of market power to leverage down reimbursements to health providers.

When a member of the council asked Randol to explain the increase in per patient spending, he couldn't.

“I didn’t create that chart, so I need to go back and understand the background, understand the numbers behind the chart and understand the factors that could potentially be driving the increase,” Randol told reporters after the meeting.

One would think that is something the state’s top Medicaid official would figure out before a meeting with the council on such a controversial issue. Then again, it’s reminiscent of his evasiveness during a June council meeting following his office’s report that Iowa was saving \$141 million annually from privatization.

He could not explain why that estimate had tripled from a few months earlier. He insisted taxpayers were saving money, but said he didn’t know how much, didn’t provide written information and scooted out of the room before reporters could question him.

Apparently Iowans are just supposed to have faith Medicaid privatization is good for taxpayers.

Well, they don’t. They shouldn’t. And one doesn’t need a degree in actuarial science to tease out a likely reason for increased spending.

For-profit insurers want to pocket as much money as possible. The companies contracted by Iowa have demanded and received more and more public dollars. They were recently granted a \$344 million pay increase by the Reynolds administration, though it remains to be seen where the state portion of that money is going to come from.

Also, the insurers can use up to 12 percent of Medicaid money for “administration.” That amounts to hundreds of millions of taxpayer dollars annually not spent on knee replacements, heart surgeries, drugs, mental health counseling and other actual care for Iowans.

Before privatization, state-managed Medicaid had much lower administrative costs, did not seek to turn a profit and was not beholden to shareholders. As the LSA analysis shows, the state kept cost increases very low.

That is the difference between three years ago and today.

In fact, the state’s own reports provide troubling glimpses of cost increases realized under Medicaid privatization.

In fiscal year 2015 — the year before privatization was implemented — the average per person cost for residential care of the most profoundly disabled was about \$147,000. Three years later, the cost is \$183,000.

In 2015, the most severely disabled people being served at home cost an average of \$40,000. The expense has shot up to \$54,600 despite numerous allegations the private insurers have slashed in-home care for disabled people.

There is no evidence these most vulnerable Iowans have received more and better services the past few years. Just the opposite, according to complaints, lawsuits and reporting by the Register.

Since privatizing Medicaid, the money recovered by the state for cost avoidance, recovery, errors and fraud has been cut in half — from about \$320 million in 2015 to about \$170 million.

Where are the explanations for all this?

Randol, who left the Kansas Medicaid program in shambles to work for Reynolds, is supposed to provide them.

But he doesn't. Neither does his boss. Reynolds continues to defend privatization, even in light of her own administration's estimates it is costing taxpayers more. Iowans, who are bankrolling this experiment, should remember that when they vote in November.

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03

Aug
2020

New Dartmouth Study Shows That Greater Financial Integration Generally not Associated with Better Healthcare Quality

by Timothy Dean

The COVID-19 pandemic has led to severe financial stress for both hospitals and physician practices, raising serious concerns that many may either close or be purchased by larger organizations. Such consolidation is well-recognized to lead to higher prices. Whether it will lead to better quality of care is less clear.

A new study published in the August Issue of *Health Affairs*, based on the first comprehensive national survey of physician practices, hospitals and health systems, found that larger, more integrated systems do not generally deliver better quality. "We looked at a broad range of quality measures and compared independent hospitals and practices with those owned by different kinds of health systems," said Elliott Fisher, MD, MPH, lead author and professor of medicine and health policy at Dartmouth. "In no case did we find that ownership by larger, more complex health systems was associated with better quality."

Another key finding from the study was the remarkable degree of variation in quality scores across hospitals and physician practices, regardless of whether they were independent or owned by larger systems. "This degree of variation points to tremendous opportunities to improve the quality of care in both hospitals and practices," said Stephen Shortell, PhD, Professor of the Graduate School, University of California, Berkeley. "We must continue to put in place the incentives and programs needed to drive improvement."

The research team assessed the degree to which hospitals and physician practices under several different ownership structures—including financial independence and financial integration with larger health systems—adopted care delivery and payment reforms intended to improve quality. They analyzed data from the National Survey of Healthcare Organizations and Systems, which included responses from 2,190 physician practices and 739 hospitals that were collected between June 2017 and August 2018. The surveys included questions about care for complex, high-need patients; participation in quality-focused payment programs; screening for clinical conditions and social needs; and use of registries and evidence-based guidelines.

"The policy implications of this research are clear," said Carrie Colla, PhD, professor of health policy and clinical practice at Dartmouth, who worked as a policy advisor in Congress during a recent sabbatical. "With COVID-19 wreaking financial havoc on smaller healthcare organizations, policy makers—both at the federal and state levels—should ensure that purchases of practices and hospitals adhere to current antitrust law. They should also consider financial support for those most threatened by the pandemic."

This research is part of Dartmouth's broader efforts as one of three national Centers of Excellence on Health System Performance to understand how health systems' use of evidence-based innovations affects healthcare quality, delivery, and costs. Dartmouth receives funding for this work from the Agency for Healthcare Research and Quality and collaborates with researchers at the University of California, Berkeley; the University of

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PubMed Basics

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August 27, 2021

Neurology Grand Rounds

August 27, 2021

Systematic Review Office Hours

August 27, 2021

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Susan and Richard Levy Health
Delivery Incubator: AVOID an
Project Reports", Colleen M.
Kershaw, MD, Lauren G. Gilst
and Susan P. D'Anna, APRN

September 3, 2021

Medicine Grand Rounds "The
and Science of Diagnostic
Reasoning", Andre Mansoor, MD

California, San Francisco; the University of North Carolina at Chapel Hill; Harvard University; and the Mayo Clinic.

The Dartmouth Institute for Health Policy and Clinical Practice is a world leader in studying and advancing models for disruptive change in healthcare delivery. The work of Dartmouth Institute faculty and researchers includes developing the concept of shared decision-making between patients and healthcare professionals, creating the model for Accountable Care Organizations (ACOs), and introducing the game-changing concept that more healthcare is not necessarily better care.

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Tags: COVID-19, The Dartmouth Institute



Written by
Timothy Dean

Tim Dean is a Communications Manager and writer in the Geisel Office of Communications and Marketing.

September 10, 2021

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The Telegraph
August 20, 2021


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Attention all innovators !!

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September 18, 2020 01:00 PM

Michigan health plans post rosy profits first half 2020; Blues Cross income lower than 2019

JAY GREENE □ □ □

and Modern Healthcare

- Michigan Blue Cross posts \$100 million lower net income first six months of this year
- State's 11 health plans posted average margins of 6.2 percent, up from 4.2 percent
- Medical claims beginning to normalize second half of year after COVID-19 disruptions

Blue Cross Blue Shield of Michigan spending on medical care fell almost 8 percent in the first six months of 2020 and administrative costs rose about 35 percent during the pandemic.

Michigan health insurers posted strong profits during the first six months of this year as the COVID-19 pandemic swept through the state with nearly 115,000 confirmed cases to date.

Leading all insurers, Blue Cross Blue Shield of Michigan posted \$556.1 million in net income during the first six months of this year, 2.6 percent lower than the same period in 2019.

Michigan Blues officials said the dip in profits came from Affordable Care Act health insurer tax as well as expenditures made to support its members during the pandemic and incentive payments advanced to providers to support telehealth services.

Spending on medical care fell almost 8 percent and administrative costs rose about 35 percent, officials for the Michigan Blues said.

"The great disruption to health care delivery caused by the pandemic has thrown off financial plans and performance across the health care ecosystem — including health systems, health insurers and medical practices," Paul Mozak, senior vice president, finance and chief risk officer, said in an email to Crain's.

Blue Cross' investment income also declined to \$77 million for the first six months compared with \$118 million during the same period in 2019, said Alan Baumgarten, a Minneapolis-

based researcher who analyzed the Michigan Blues and other health plan financial reports.

Baumgarten also said that during the first half of 2019 Blue Cross received \$53 million back from the Internal Revenue Service, but in 2020 it started paying taxes again, shelling out \$31.2 million.

Mozak said that as medical services continue to come back to normal levels, Blue Cross projects the remainder of 2020 "to give us more predictable financial performance."

The other 11 health plans and insurers in Michigan also posted strong profits for the first half of the year, Baumgarten said.

For the Michigan health plans, net income increased 54 percent to \$551.3 million from \$353.8 million, said Baumgarten, who used data from the state Department of Insurance and Financial Services. Average profit margins increased to 6.2 percent from 4.2 percent.

"The financial results are very good, and much improved over the same period a year ago," Baumgarten said in an email to Crain's.

Leading the pack is Blue Care Network, which posted a 9.4 percent margin and \$193.2 million in net income. Health Alliance Plan, which is part of Henry Ford Health System, earned \$69.5 million for a 9.1 percent margin, DIFS said.

Others include two Medicaid plans. Molina Health Care recorded an 8.4 percent margin with income of \$75.3 million, and Meridian Health Plan, which posted \$60.6 million income for a 5.4 percent margin. McLaren Health Plan hit a 7.4 percent with \$29 million income and Priority Health came in at 2.5 percent margin and \$47.8 million in total profits.

Michigan health insurance average medical loss ratios decreased to 77.3 percent from 83 percent, indicating that some health plans must issue rebates to consumers or businesses based on Affordable Care Act rules.

The ACA requires insurance companies to pay annual rebates if the medical loss ratio — how much insurers pay for medical expenses — for groups of health insurance policies issued in a state is less than 85 percent for large employer group policies and 80 percent for most small employer group policies and individual policies.

Baumgarten said Blue Cross' medical loss ratio dropped to 73.9 percent from 82 percent. Administrative expenses nearly doubled to \$861 million from \$539 million, he said.

Insurance coverage

Another effect from the COVID-19 pandemic is that 3.3 million people have lost their employer-sponsored health insurance in recent months with 2 million becoming uninsured, according to a new report from the Urban Institute.

The report said some people moved to Medicaid, which helped minimize the number of uninsured.

While commercial enrollment data is unavailable this year for Michigan, the state's Healthy Michigan Medicaid program has added more than 110,000 enrollees since January to 787,052 adults in September from 672,898, the state Department of Health and Human Services said.

State officials announced Friday that nearly all health insurers in Michigan have agreed to waive all out-of-pocket costs for COVID-19 testing and treatments through the end of 2020, including copays, deductibles and coinsurance. These agreements cover more than 92 percent of the commercial health insurance market in Michigan, officials said.

"Ensuring access to appropriate testing and medical treatment without financial concern is an important part of fighting this virus," Gov. Gretchen Whitmer in a news release. "We're continuing to work around the clock to slow the spread of this virus and keep people healthy, and I am thankful that Michigan's health insurers have continued to step up to do their part."

Nationally, many Blues Cross plans posted strong profits in the face of coronavirus challenges, according to an analysis by Modern Healthcare.

The Crain Communications Inc. publication's examination of not-for-profit Blues companies revealed that some saw a big jump in income as they benefited from the widespread deferral of expensive elective procedures, which resulted in fewer claims to pay.

For example, Health Care Service Corp., which operates plans in Illinois and other states, raked in \$2.6 billion in net income in the first half of the year, up 14.5 percent over the same six months in 2019. Pittsburgh-based Highmark and subsidiaries nearly doubled net income to \$538.3 million.

Even though many were profitable, more than a dozen companies reported lower net income and weaker margins compared with the same period in 2019. Large Blues plans in California, Florida and North Carolina were among those that performed relatively worse.

Many plans were saddled with higher administrative expenses and some were hit with lower investment income, putting pressure on the bottom line, analysts said. Some expenses were

driven by the companies' attempts to give back excess premium revenue by reducing member costs, beefing up benefits or propping up physician practices.

Moreover, the Blues' business models, which focus heavily on selling employer-based coverage, made them more vulnerable to the economic downturn, which saw job and health coverage losses spike, experts said.

"To the extent that you see margins compressed more so by the Blues, it's probably got a lot to do with the fact that the economy has hit small and medium-sized businesses so hard relative to some of the larger ones, that it's really taken a toll on the Blues' ability to earn margin," said Nate Akers, a director at consultancy Guidehouse whose clients include some of the largest Blues plans.

The variation in financial performance during the pandemic diverges from that of the national, publicly traded health insurers, all of which grew profits in the first half of the year as patients put off routine care and hospitals postponed nonurgent services, primarily during the second quarter. For-profit Blues affiliate Anthem, for instance, grew net income 41 percent to \$3.8 billion in the first half.

Modern Healthcare analyzed the results of dozens of independent Blues companies using financial statements obtained from the National Association of Insurance Commissioners and data from the California Department of Managed Health Care. The analysis excluded subsidiaries unrelated to health insurance and filings that lacked detailed information on premiums, claims or expenses. It also excluded publicly traded insurers Anthem, which operates in 14 states, and Puerto Rico-based Triple-S Management Corp. For some companies, quarterly reports were available for only some of their operations.

The Blues' performance varied widely. Across the companies for which quarterly reports were publicly available, 18 reported lower net income and 17 reported worse margins compared with the first half of 2019. Another 14 companies reported better profits.

Collectively, Blues plans in the analysis grew revenue 4 percent to \$114.6 billion in the first six months of 2020 compared with the same period in 2019. They reported combined net income of \$7.9 billion, an uptick of 1.3 percent, or \$103.1 million.

Most of the insurers spent less on health care benefits during the pandemic. Spending on benefits, including prescription drugs, decreased 1.2 percent, or \$1.1 billion, across the plans to \$90.9 billion in the first half. However, nearly all the companies had higher general administrative expenses. Combined, those costs soared 44 percent to \$12.9 billion.

Several companies and the Blue Cross and Blue Shield Association attributed the jump in administrative costs to an Affordable Care Act tax on health insurers that is in effect this year. That nondeductible tax, which must be recorded as an administrative expense in full at the start of the year, was suspended for 2019 and is permanently repealed beginning next year. It's expected to bring in \$15.5 billion in 2020.

Deep Banerjee, managing director at S&P Global, said insurers could also be using excess income to speed up incurring nonmedical expenses.

"They might have thought they want to spend \$100 million over the next 12 months or 24 months, but seeing how good the first half of the year has been, they take advantage and make that spending now instead of having to wait," he said.

For some of the Blues, the benefit of lower health care utilization outweighed any extra costs. "The companies we've seen so far are looking strong in terms of operating earnings," said Brad Ellis, a senior director at Fitch Ratings. He said that lower health care utilization was "the single strongest driving factor" in the first half of the year.

Officials with Health Care Service Corp. said its medical claims dropped sharply due to stay-at-home orders. Its revenue rose 8.5 percent to \$21.3 billion, and its profit margin grew to 12.2 percent from 11.5 percent. The decline in medical claims during the coronavirus crisis offset an increase in benefits and administrative expenses driven by growth in Medicaid and group membership, the company said.

Blue Cross and Blue Shield of Minnesota, Blue Cross and Blue Shield of Tennessee, Harrisburg, Pa.-based plans Capital Blue Cross and Excellus Blue Cross and Blue Shield also attributed their higher bottom lines to temporary care deferrals. All said they are already seeing claims volumes return to normal.

But even with the benefit of lower utilization, some other Blues insurers reported weaker earnings, which they said reflected efforts to reduce the cost of their health plans through lower premiums or member cost-sharing.

Gurpreet Singh, U.S. health services sector leader at PwC, also noted that after record profitability in 2018 and 2019, most Blues plans had very little or no price increases for 2020, which was "a very deliberate move to moderate profits."

Sally Rosen, senior director at credit rating agency A.M. Best, said some of the actions that companies took to help members and providers — whether it be premium relief, cost-sharing

waivers for services like telehealth, or other community investments made during the pandemic — could drive up administrative or claims expenses, depending on the initiative.

Inline Play

Source URL: <https://www.crainsdetroit.com/health-care/michigan-health-plans-post-rosy-profits-first-half-2020-blues-cross-income-lower-2019>

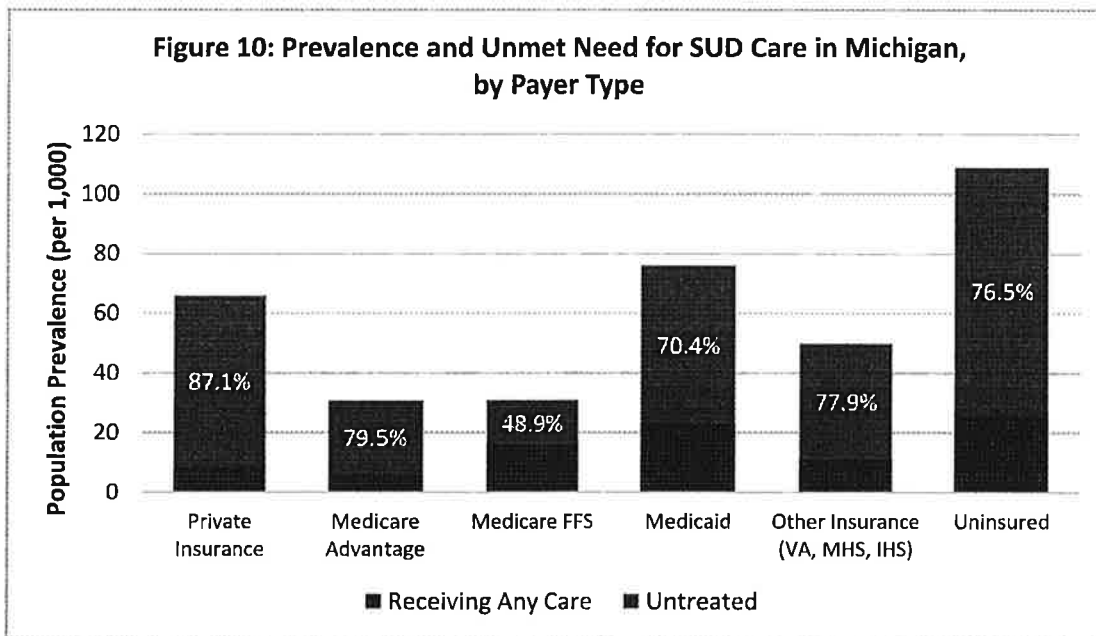
ACCESS TO BEHAVIORAL HEALTH CARE IN MICHIGAN

Final Report

Corwin Rhyan, Ani Turner,
Emily Ehrlich, and Christine Stanik

July 2019





While population and claims data allow us to separate Medicare Advantage and Medicare FFS, it is important to note that the prevalence data are not available by Medicare plan type. If, for example, individuals enrolled in Medicare Advantage plans had lower rates of prevalence of behavioral health conditions than those enrolled in FFS, then the differences in the share of unmet need between the two Medicare populations shown here would be overstated.

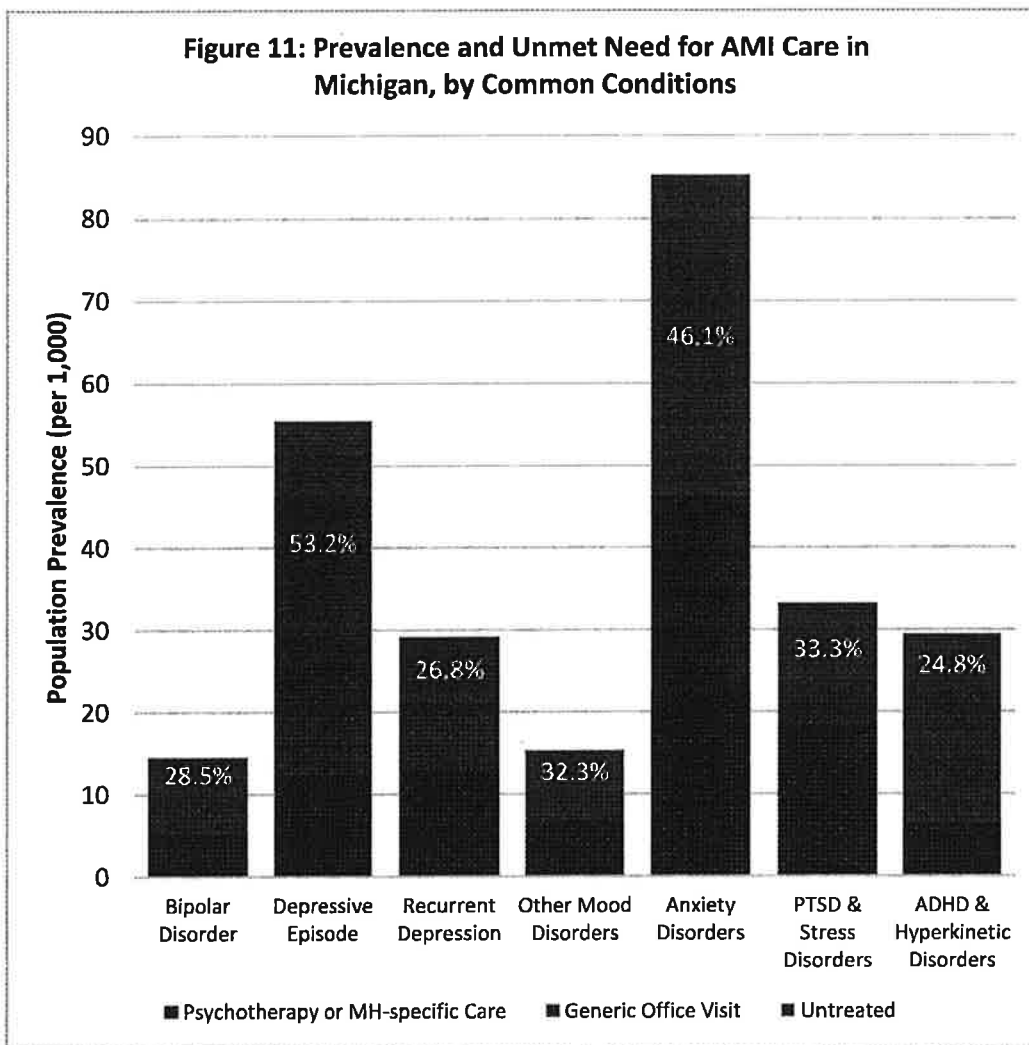
Results for Common Conditions

We examined results by common mental health and substance use disorder conditions for the Medicaid, Medicare, and privately-insured populations in Michigan.

COMMON MENTAL HEALTH CONDITIONS

Unmet need for AMI in Michigan is greatest for the more prevalent, mild-to-moderate conditions. Figure 11 shows the variation in estimated prevalence and unmet need for some of the most common mental health condition diagnostic categories. The conditions with the largest shares going untreated are *anxiety disorders* and *depressive episode*. More serious conditions such as *bipolar disorder*, *recurrent depression*, and *post-traumatic stress disorder (PTSD)* and *other stress disorders* are less prevalent among Michiganders and show lower shares going untreated.

For those treated, Figure 11 also distinguishes between individuals who received a psychotherapy visit or specific mental health treatment (shown in blue) versus those who received a generic office visit with the primary purpose of treating a mental health condition (shown in green). Michiganders with *anxiety disorders*, a *depressive episode*, and *attention-deficit hyperactivity disorder (ADHD)* and *hyperkinetic disorders* are most likely to receive care under a generic office visit.



COMMON SUBSTANCE USE DISORDERS

Among common SUDs, prevalence and unmet need is greatest for alcohol use disorder (Figure 12). Michiganders are experiencing alcohol use disorder at about four times the rate as cannabis or opioid use disorder, and more than 85% of those with alcohol use disorder are not receiving care. While lower in prevalence, unmet needs are still large for the other major disorders; more than 80% of those with a cannabis use disorder are not receiving care, as are one-third of those with an opioid use disorder.

Within Our Reach

CONCRETE APPROACHES TO BUILDING A WORLD CLASS PUBLIC MENTAL HEALTH SYSTEM IN MICHIGAN



1

Build upon the strengths of Michigan's nationally recognized county-based public mental health system

- Longstanding **strong performance** against the state-established and nationally recognized performance standards
- Nation-leading **de-institutionalization success** - moving care to the community
- **High rankings against national standards** of behavioral health prevalence and access to services
- Proven ability to **control costs** over decades
- Designed and implemented hundreds of **healthcare integration** initiatives
- Use of a large number of **evidence-based and promising practices**



SCAN THE QR CODE
OR VISIT
<https://bit.ly/3qznhkj>

See the Center for
Healthcare Integration
and Innovation study
"A Tradition of Excellence and
Innovation: Measuring the
Performance of Michigan's
Public Mental Health System"
for detail on these strengths

2

Focus on areas where continual advancement is needed and for which concrete solutions exist and can be readily strengthened and expanded

Area where system advancement is needed	Concrete approach to system advancement
IMPROVE ACCESS to comprehensive set of state of the art mental health services to all community members (including those with private commercial insurance, Medicaid, Medicare, and uninsured)	SUPPORT the implementation of Michigan's Certified Community Behavioral Health Centers (CCBHC) in the initial pilot sites and then scale up statewide
	RESTORE STATE GENERAL FUND DOLLARS cut from the CMH funding reserved to serve persons not enrolled in Medicaid
	SUPPORT AND EXPAND first episode psychosis (FEP) treatment approach - already piloted in Michigan communities
IMPROVE access to inpatient psychiatric care and residential alternatives to hospitalization	SUPPORT the creation and expansion of Psychiatric Residential Treatment Facilities (PRTF)
	SUPPORT inpatient psychiatric hospitals and wards with physical plant and staffing changes , helping hospitals better serve persons with complex mental health needs
ADDRESS behavioral health workforce shortage	INCREASE capitation payment to public mental health system to allow for competitive wages and benefits for direct support professionals
	EXPAND federal (National Health Service Corps) and state loan repayment programs to attract psychiatrists, social workers, psychologists, and other clinicians to underserved Michigan communities
PROVIDE WHOLE PERSON CARE , especially to those with complex needs	SUPPORT expansion of Behavioral Health Homes (BHH) and Opioid Health Homes (OHH)
	SUPPORT full funding and expansion of hundreds of existing health care integration efforts led by public mental health system and primary care partners
IMPROVE access to and coordination of CRISIS SERVICES	SUPPORT creation and expansion of Crisis Stabilization Units (CSU) - recently contained in statute
	SUPPORT and fully implement Michigan Crisis and Access Line (MiCAL)
	SUPPORT implementation of 988 crisis line system - recently approved by FCC
	SUPPORT funding for mental health crisis response teams - partnering with law enforcement and first responders at scene of crises

Certified Community Behavioral Health Clinics in Michigan



The future is now. The Governor and legislators have made financial investments that improve quality care. Let us continue the momentum. Any successful healthcare integration effort must first start with the person. Michigan's public mental health system is the leader in person-centered care, leading with Certified Community Behavioral Health Clinics (CCBHC).

CCBHC's dramatically increase access to mental health and substance use disorder treatment while expanding the state's capacity to address acute mental health crises. They also:

- **ADOPT** a standard model to improve the quality and availability of addiction and mental healthcare
- **PROVIDE** care to people regardless of insurance type, geography, or the ability to pay. Those typically include uninsured, underinsured, underserved, low income individuals on Medicaid, and active-duty military or veterans

CCBHC's are nonprofit organizations or units of a local government behavioral health authority. They must directly provide (or contract with partner organizations to provide) nine types of services, with an emphasis on the provision of 24-hour crisis care, evidence-based practices, care coordination with local primary care and hospital partners, and integration with physical health care.



CCBHC's directly...



Increase access to telehealth and 24 hour mobile crisis services



Decrease serious psychological distress



Reduce suicide and overdoses by helping consumers feel healthier overall



Address access to addiction treatment and mental health services



Bring in more federal funding



Provide better services for veterans



Increase the use of Medically Assisted Treatments



Reduce wait times for care

The 24 CCBHC sites include:

- Calhoun County Mental Health
- CNS Healthcare
- Community Mental Health Authority of Clinton, Eaton, Ingham Counties
- Detroit Recovery Project
- Development Centers, Inc.
- Easterseals Michigan
- Faith Hope and Love Outreach Center
- Genesee Health System
- HealthWest
- Hegira Programs Inc Psychotherapy
- Integrated Services of Kalamazoo
- Judson Center
- LifeWays Community Mental Health
- Macomb County Community Mental Health - Administration
- Neighborhood Service Organization
- Network180 Mental Health
- Northeast Guidance Center
- Saginaw County Community Mental Health Authority
- Southwest Counseling Solutions, Inc.
- St. Clair County Community Mental Health
- Team Wellness Center
- The Guidance Center
- Washtenaw County Community Mental Health
- West Michigan Community Mental Health



The Process

Integration at the Person-Level

1

Intake

CCBHC's work together with partners to develop an integrated person-centered plan to support whole person care. This includes but is not limited to developing and understanding each consumer's psychosocial, physical health, behavioral health, substance use, and social determinant strengths and needs.

2

Prioritize health goals

Based upon prioritized needs and areas of risk, consumers enter services with prioritized goals including physical health screening, primary care coordination, and comprehensive supports coordination.

3

Full array of services

CCBHC consumers have access to a full array of evidence-based physical and behavioral health interventions that support health outcomes—from smoking cessation programs, to nutrition management, to weight loss and exercise planning, to whole health action management strategies.

4

Integration of physical & behavioral health needs

All behavioral interventions are tied to the physical health needs of the individual consumer. These efforts are also supported by peers fully trained to implement evidence-based practices and connect with consumers based on their own physical and behavioral health recovery.

5

Producing real life outcomes

Based on national data and Michigan-based metrics, consumers receive better quality of care including these essential services of CCBHC's.



Crisis mental health services



Patient-centered treatment planning: Screening, assessment & diagnosis, including risk assessment



Outpatient mental health & substance use services



Primary care screening & monitoring of key health indicators/health risk



Intensive, community-based mental health care for members of the armed forces & veterans



Psychiatric rehabilitation services



Peer support & family supports



Targeted case management

Behavioral Health Homes & Opioid Health Homes

The future is now. Any successful healthcare integration effort must first start with the person. Michigan's public mental health system is the leader in person-centered care.

The Behavioral Health Home (BHH) and Opioid Health Home (OHH) provides comprehensive care management and coordination of services to Medicaid beneficiaries with a serious mental illness, serious emotional disturbance or opioid use disorder.

For enrolled beneficiaries, the BHH or OHH will function as the central point of contact for directing person-centered care across the broader health care system. Beneficiaries will work with an interdisciplinary team of providers to develop a person-centered health action plan to best manage their care.



Goals for Behavioral and Opioid Health Homes

Michigan has three goals for the BHH and OHH programs:

- 1 Improve care management of beneficiaries with serious mental illness, serious emotional disturbance, or opioid use disorder
- 2 Improve care coordination between physical and behavioral health care services
- 3 Improve care transitions between primary, specialty and inpatient settings of care

BHH and OHH have demonstrated great cost savings for the state (\$103-366 per member, per month savings), thus the Michigan Department of Health and Human Services expanded coverage in the fiscal year of 2021 budget.

It is conservatively projected that when these programs are fully implemented, the BHH will serve up to 20,000 beneficiaries and the OHH will serve up to 5,000 beneficiaries throughout the state.



Behavioral Health Homes operate in:

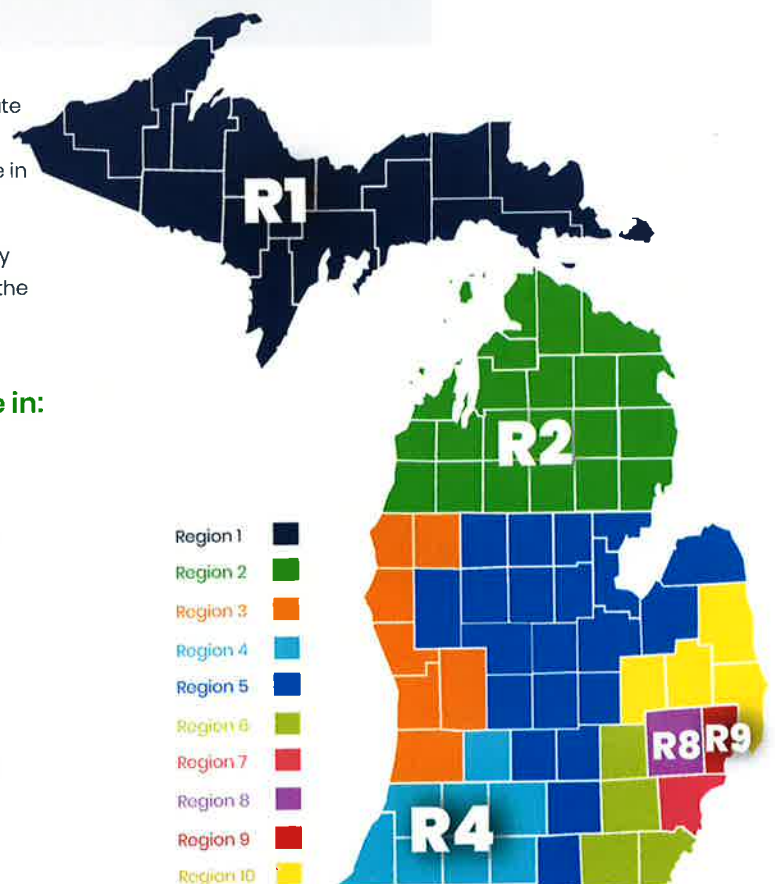
*PIHP stands for prepaid inpatient health plan

- The upper peninsula (PIHP Region 1)
- The northern lower peninsula (PIHP Region 2)
- The east side of the state (PIHP Region 8)



Opioid Health Homes operate in:

- The upper peninsula (PIHP Region 1)
- The northern lower peninsula (PIHP Region 2)
- The west side of the state (PIHP Region 4)
- The east side of the state (PIHP Region 9)



Real Life Outcomes – Federally Required Core Health Home Metrics

- BHH enrollees showed greater cost reductions

19% decrease in costs per member/per month –
around \$103 per member/per month

- Increased seven-day follow-up appointments after hospitalization—leading to reduced wait time for care
- Decreased inpatient hospitalization
- Decreased inpatient hospital length of stay
- Decreased hospital re-admissions
- Increased screenings for adult body mass
- Increased initiation and engagement of alcohol or other drug dependence treatment
- Decreased healthcare expenditures overall
- Increased community education and preventative measures



Delivery System Transformation and Behavioral Health Integration

The future is here. There are steps lawmakers and providers can take to continue serving our most vulnerable citizens. These steps help existing programs that already demonstrate patient-centered care, cost savings, and are backed by the Michigan Department of Health and Human Services.

- **OVERCOME** traditional barriers of care by continuing integration of Michigan's physical and specialty behavioral health delivery systems
- **INCREASE** communication between systems of care to result in greater care coordination for people
- **UTILIZE** an innovative payment model including a bundled case rate and value-based payments to maximize savings





Strengths of Michigan's Public Mental Health System

The performance of Michigan's public mental health system surpasses other states and systems, as measured by dimensions of health care quality and innovation.

CHI2 drew from national and Michigan-based sources to demonstrate services available to support residents seeking mental health services.

Michigan's public mental health system is nationally recognized as one of the most comprehensive, innovative, person-centered and community-driven systems in the country.

Through the use of community-based rather than institution-based care, Michigan's public mental health system returns a 37-fold investment on the state dollars that fund that system, according to a report released by the Center for Healthcare Integration and Innovation (CHI2).

The report, entitled "[A Tradition of Excellence and Innovation: Measuring the Performance of Michigan's Public Mental Health System](#)," examines the performance of Michigan's public mental health system against several state-established and national standards.



Strong, longstanding performance against state established and nationally recognized performance standards:

Michigan's public mental health system has exceeded the state established standards for 37 of the 38 standards measured. For the one standard not exceeded, the system was below the state standard by only 1.63% from the 95% standard.



A national leader in de-institutionalization and community-based care:

Michigan's use of state psychiatric hospitals compared to the rest of the country is significantly less, with other states using state psychiatric hospitals 17 times more, per-capita, than Michigan—a testament to the state's strong movement to a de-institutionalized and community-based system of care. In fact, if the \$3.469 billion that is currently used to serve over 350,000 Michiganders per year was spent solely on the provision of long-term care at state psychiatric hospitals and developmental disability centers, then those dollars would only serve 9,500 people per year.



High rankings against national standards of behavioral health prevalence and services accessibility:

Michigan ranks sixth nationally in serving adults, as cited by Mental Health in America in 2020.



Proven ability to control costs over decades, resulting in major cost savings:

When compared to Medicaid cost increases seen across the country, from 1998 to 2015, Michigan's public mental health system has saved the state of Michigan \$5.27 billion. If extrapolated through 2024, Michigan could save over \$12 billion. The report found the approaches that the public system uses to control costs contrast sharply with the approach of private systems.



Pursuit of healthcare integration and evidence-based practices:

More than 620 integration efforts led by the public mental health system—weaving mental health care with primary care—take place throughout the state to lower costs of services, increase access to care, improve preventative intervention and serve the whole person.



Evidence-Based Practices

Michigan's public mental health system has been a national leader in the Evidence-Based Practice movement, pioneering evidence-based and promising practices for decades, including:

- Assertive Community Treatment
- Assisted Outpatient Treatment
- Psycho-Social Rehabilitation/Clubhouse
- Cognitive Enhancement Therapy
- Dialectical Behavior Therapy
- Family Psychoeducation
- Motivational Interviewing
- Person Centered Planning, Training, and Evaluation
- Self Determination
- Independent Person-Centered Planning Facilitation
- First Episode Psychosis Services
- Eye Movement Desensitization and Reprocessing
- Peer Services
- Consumer-Driven Services
- Homebased Treatment Services for Children, Adolescents, and their Families
- Competitive Integrated Employment practices
- Trauma-Informed Care
- Treatment Courts
- Sequential Intercept Model of Jail Diversion/Decarceration

Efficient – Low Overhead Means More Dollars Spent on Care

94% Medical loss ratio

(i.e. the percentage of dollars spent on actual care)

Michigan's public PIHP system has a statewide average spent on administrative costs of 6%



Results-Oriented

Thanks to CMHA's work to make the state's behavioral mental health system value-based, innovative and evidence-based, Michigan ranked 15th in the 2019 State of Mental Health in America report. This puts Michigan among the top 30% for awareness and access to mental health.

..... **MICHIGAN RANKS**

6th
in the nation

for services & outcomes
for adult services

20th
in the nation

for services & outcomes
for children's services

15th
in the nation

for access to care for both
adult & children's services

Serving Thousands of Michiganders

10

public regional
entities

46

public community
mental health systems

100+

provider
organizations

100,000+

persons providing services in Michigan's
public mental health system

300,000+

Michiganders served
annually

The Community Mental Health Association of Michigan is the state association representing Michigan's public Community Mental Health (CMH) centers, the public Prepaid Inpatient Health Plans (PIHP – public health plans formed and governed by CMH centers) and the private providers within the CMH and PIHP provider networks. For more information, please visit CMHA.org or call 517-374-6848.